

SURGERY FOR THE TREATMENT OF MORBID OBESITY - Page 1 of 3
FOLLOW-UP REPORTS

Indiana State Department of Health
State Form 53322 (6-07)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

- ① Print firmly and neatly. ③ Fill in circles like this: ● ④ Print capital letters only
② Only use pens with blue or black ink. Not like this: ✗ and numbers completely
Mark mistakes like this: ✗ inside boxes. A 2 C 3

Section 1. Patient Information

Change of patient address and/or phone number
☐ Yes ☐ No

Last Name

First Name

MI

Phone Number

Number & Street Address

City

State

ZIP Code

County

Date of Birth (mm/dd/yyyy)

Age (years)

Sex:
☐ Male ☐ Female ☐ Unknown

Ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race (select all that apply):
☐ Asian ☐ White
☐ Black or African American ☐ Other/Multiracial
☐ American Indian or Alaska Native ☐ Unknown
☐ Native Hawaiian or Other Pacific Islander

Section 2. Surgery Follow-up Information

Select the follow-up interval for this report:

☐ 30 days ☐ 60 days ☐ 90 days ☐ 1 year ☐ 2 years ☐ 3 years ☐ 4 years ☐ 5 years

Initial Surgical Procedure(s) Performed:

CPT Code

CPT Code

CPT Code

CPT Code

CPT Code

Follow-up Measurements:

BMI: _____

Waist Circumference: _____
Inches

Comorbidities:

ICD-9-CM code

ICD-9-CM code

ICD-9-CM code

ICD-9-CM code

ICD-9-CM code

Complications and Side Effects:

Death? ☐ Yes ☐ No

If Yes, cause of death (ICD-10 code)

Date of death (mm/dd/yyyy)

Complications of initial surgery? ☐ Yes ☐ No

If Yes, complication(s):

ICD-9-CM code

Date of complication onset

ICD-9-CM code

Date of complication onset

ICD-9-CM code

Date of complication onset

ICD-9-CM code

Date of complication onset

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Complications (continued):

☐ If Yes, date of hospitalization (mm/dd/yyyy) Length of stay in days Name of facility

Status at time of discharge (selet only one):

- ☐ Against Medical Advice ☐ Nursing Facility
☐ Routine/Self-care ☐ Other Hospital
☐ Home Health Care ☐ Other Institution, type: _____
 Rehabilitation: Hospice:
 ☐ Inpatient ☐ Home
 ☐ Outpatient ☐ Inpatient
☐ Skilled Nursing Facility ☐ Expired

Surgery for complication(s)? ☐ Yes ☐ No If Yes, date of surgery (mm/dd/yyyy): | | | / | | | / | | |

Procedure(s) performed:

CPT Code CPT Code CPT Code CPT Code CPT Code

Other invasive treatment required? ☐ Yes ☐ No

If Yes, type and description:

Side effects of initial surgery? ☐ Yes ☐ No

If Yes, side effect(s):

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Hospitalization for side effect(s)? ☐ Yes ☐ No

☐ If Yes, date of hospitalization (mm/dd/yyyy) Length of stay in days Name of Facility

Status at time of discharge (select only one):

- ☐ Against Medical Advice ☐ Nursing Facility
☐ Routine/Self-care ☐ Other Hospital
☐ Home Health Care ☐ Other Institution, type: _____
 Rehabilitation: Hospice:
 ☐ Inpatient ☐ Home
 ☐ Outpatient ☐ Inpatient
☐ Skilled Nursing Facility ☐ Expired

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Surgery for side effect(s)? ☐ Yes ☐ No **If Yes, date of surgery (mm/dd/yyyy):** / /

CPT Code CPT Code CPT Code CPT Code CPT Code

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____/____/____
Date Form Completed (mm/dd/yyyy)